COMMENTARY

The Diminishing Role of Psychiatry in Group Psychotherapy:

A Commentary and Recommendations for Change

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ABSTRACT

In this article, the authors provide an overview of the declining role of the psychiatrist in group psychotherapy. They surveyed 18 psychiatry residency training programs and found an overall decreased focus on group therapy training. The authors opine on the causes for this decline and why group therapy training is important for psychiatry residents, as well as provide several recommendations to encourage the inclusion of group psychotherapy training in residency programs. The authors believe that acquiring group therapy skills and providing group therapy can be an enjoyable experience for psychiatrists and beneficial to the patients.

A BRIEF HISTORY OF GROUP THERAPY TRAINING IN PSYCHIATRY

Group therapy training in psychiatry residency programs in the United States was at its height from the 1950s to 1970s.[1,2] In the 1950s, approximately 48 percent of residents were exposed to group therapy training, and group therapy training was considered to be highly valued by residents who received such training.[1] According to Pinney et al,[2] the number of residents exposed to group therapy training increased to 78 percent in the 1970s. However, in the early 1990s, there was emergence of psychobiological orientation in psychiatry programs, which, in our opinion, led to decreased emphasis on psychotherapy training and increased empahsis on psychopharmacology and behavioral and empirical criteria as the basis of treatment.[1,3] This focus stood in contrast to teaching traditional characterological and dynamic formulations, and was exemplified by the emergence and utilization of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)*.[4] In our opinion, this biochemical determinism and the

DSM-III resulted in physician training in the field of psychiatry for both diagnoses and treatment, with little attention devoted to consideration of dynamic functioning in patients and even less attention to the potential power of group dynamics and nonobvious determinants of human behavior.

A SURVEY OF UNITED STATES-BASED RESIDENCY PROGRAMS

In order to obtain a more systematic picture of the current circumstances regarding resident training, we interviewed a sample of chief residents from 18 United States-based psychiatry residency programs. Seventeen of the interviews were done over the phone by the authors. One chief resident mailed the questionnaire. Eash interview took approximately 15 minutes to complete. The questionnaire contained questions pertaining to the nature of group psychotherapy training, quality of supervision, and opportunities about learning group psychotherapy. Questions about general interest of residents in group psychotherapy were also included. Among the programs surveyed, we found the following:

1. Formal group psychotherapy training was virtually absent in residency training in Post-Graduate Years (PGY) I and II. Most of the programs had optional electives for PGY III and IV.
2. The vast majority of the program residents had low to moderate interest in learning group psychotherapy.
4. Six programs exposed residents to inpatient group psychotherapy, but only one program taught and supervised residents on how to conduct such groups on a regular basis.
5. Seven programs had T- groups (i.e., sensitivity training groups) as a part of their regular curriculum. Eleven programs did not have T-groups.
6. Only one program employed experiential teaching methods as a part of group therapy training (e.g., the utilization of real-time observations).
7. There was a widespread perception that the existing training on group psychotherapy is not effective.

WHAT'S CAUSING THIS TREND?

Bioscientific forces. We believe that biochemical science, especially the development of serotonin reuptake inhibitors (SSRIs) and, to a lesser degree, second-generation antipsychotics, has had an extraordinary impact on psychiatry's diminishing role in group psychotherapy. In the past, and as late as the 1980s, the majority of patients with psychoses (except bipolar disorder) and depression were treated as if their illnesses were of functional etiology, and the treatment was, for the most part, psychodynamically oriented.[5] During the 1970s, however, the development of neuroimaging techniques pertinent to psychosis emerged within many quarters of psychiatry.[6] And in the 1980s and 90s, new pharmaceuticals (e.g., SSRIs and second-generation antipsychotics) were also introduced, and these drugs became powerful tools in the hands of psychiatrists. These drugs seemed to have dramatic and rapid effect in reducing many severe depressive and/or psychotic symptoms, even without the use of psychotherapy. We believe these bioscientific developments contributed to the de-emphasis on functional etiologies and psychodynamics in mental illness. We also believe that use of these medications made it easier (and more profitable) for many psychiatrists to focus on psychopharmacology rather than on the relatively greater challenges involved in conducting psychotherapy, especially considering that other disciplines (e.g., psychology and social work) were fulfilling many of the psychotherapy needs of patients for lesser fees.[7]

Today, there are large segments of psychiatry that view psychotherapy as a secondary form of treatment that is not particularly efficacious.[8] We believe the results of our survey illustrate that residency programs produce psychiatrists with little training in group psychotherapy.

Economic forces. The impact of managed care on the psychiatrist as an individual psychotherapist and as a group psychotherapist has been as powerful as developments in the field of pharmacology. This may be due to the fact that psychiatrists' fees are higher than psychologists and social workers,[7] and psychotherapy can be provided by those disciplines. Managed care firms have become increasingly reluctant to reimburse psychiatrists for psychotherapy services.[9] It seems that managed care firms prefer to pay the nonmedical therapy providers' lower fees and pay psychiatrists for medication treatment alone (which requires shorter and less frequent sessions, thus taking less time).

RATIONALE FOR CHANGE

The current trend toward fewer psychiatrist group psychotherapists could be reversed. We believe psychiatrists should be trained to conduct psychotherapy groups and implement group psychotherapy as a regular part of their inpatient or outpatient practice.

The Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME) emphasizes competency in various forms of therapies.[10] According to Dagg and Evans,[11] group therapy learning can facilitate learning various other forms of therapies, as well as enhance a clinician's ability to listen, and for this reason, training in group therapy should precede training in individual therapy. Gans et al[12] recommends that T-groups be included in regular psychiatric curricula.

Group psychotherapy is highly efficacious, and virtually all research

comparing it to individual treatment indicates that it is, at the very least, equal to individual therapy as a treatment modality.[13]

We believe that group psychotherapy contains a vitality and energy not often seen in individual treatment. Ideally, psychiatrists should have more than a superficial knowledge of their patients in order to treat them with maximal effectiveness, yet the time limitations imposed by managed care make this difficult. Patients seen in either brief or psychopharmacologically oriented individual treatment often "look" very different in a group, and reveal aspects of their psychological and behavioral selves that do not manifest quite as graphically in the individual consultation room.

The patient, who is only seen by the psychiatrist via infrequent, short, individual sessions focused on medication, may display very different characteristics when he or she is asked to function interpersonally with others in a group therapy setting. The group becomes a microcosm of the patient's interpersonal and familial life, offering the psychiatrist a deeper potential understanding of the patient's psyche as well as presenting an excellent picture of the patient's impact on (and how he or she is impacted by) an array of others in his or her interpersonal world. We have noted in our own program that it is common for residents to comment on how "different" their patients seem when observed in a group in contrast to the impressions the residents have of these very same patients from individual sessions.

The greater knowledge of patients afforded by seeing them function in a group setting is also one way in which the limitations placed on a psychiatrist's time by managed care can be compensated. We believe managed care, as well as competition from other mental health professionals who charge lesser fees, has limited the role of psychiatrists as psychotherapists, resulting in reduced opportunities for the psychiatrist to gain true understanding of his or her patients—of how those patients actually function in the world. The time limitation imposed by managed care reimbursement often leaves little room for the psychiatrist to do more than obtain brief medical and psychiatric histories, evaluate mental status, and make a *DSM*-type of diagnosis. It is difficult to really get to know a patient when, following an initial consultation of 30 to 60 minutes, each patient visit is restricted to 15- to 20-minute medication checks that only happen on average seven times a year per patient. On the other hand, a 60-minute group session led by a skilled group therapist will provide an enormity of data on what each patient is really like as a person.

There is economical viability of group psychotherapy as well, even in a managed care environment. Many patients' copays under managed care contracts are often sufficient to pay for the group therapy session when combined with other members of the group. In other words, many patients can participate in a group for the price of their copay, which allows the psychiatrist to earn fees that are truly workable, while maintaining affordable rates for the patients. For example, a one-hour group, which is mostly filled with talk therapy, can also serve as a medication-management visit, allowing the psychiatrist to conduct group therapy and follow medications at the same time. As an example, eight patients can be included in a group at $35.00 per patient, which totals $280.00.

RECOMMENDATIONS FOR CHANGE

We offer the following recommendations to psychiatrists who wish to increase other psychiatrists' interest in group psychotherapy:

1. Actively participate in associations such as the American Group Psychotherapy Association (AGPA) and the American Psychiatric Association (APA).
2. Form a task force within AGPA, APA, or another psychiatry association to address these concerns.
4. While the ACGME has restated and reaffirmed its commitment to the development of psychotherapy competencies in resident training, it should specifically treat group psychotherapy as a distinct treatment skill area. Encourage members of your associations to petition the ACGME to incorporate group therapy training as a competency.
5. Take an active role in encouraging the RRC to require residency programs to implement more extensive training of group psychotherapy skills for the residents.
6. Take the lead in developing a manual for training group psychotherapy in residency programs. This might be part of a group psychotherapy task force.

CONCLUSION

There is a decline in group therapy training in residency training programs in the country. Despite this, we find that residents in our program still enjoy and appreciate the experiential groups and often feel increased interest in developing group psychotherapy skills. The number of psychiatrists practicing group psychotherapy has decreased for several reasons in the last five decades, mainly due to new developments in pharmacological treatments and economic reasons. We believe it is important for psychiatrists to be trained in group therapy as it enhances their abilities to work in milieu programs like inpatient units and partial hospitalization programs. Group therapy skills can also complement a psychiatrist's skill in psychopharmacology.

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